Avera Health

Sponsored by the Benedictine and Presentation Sisters

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April 5, 2005

Commission's Secretary
Office of the Secretary
Federal Communications Commission
455 12th Street SW
Washington, DC 20554

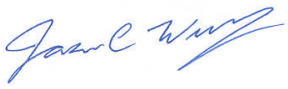
RE: Comments on February 07, 2005 "Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking" Published in the Federal Register, WC Docket No. 02-60

Avera Health is a regional non-profit healthcare delivery network that operates in over 130 communities in South Dakota, Minnesota, Iowa, and Nebraska. Support from the Universal Service Fund has had a very positive effect on our network and has allowed us to expand and provide many services to our affiliates, such as teleradiology, telehealth, distance education, Internet-based education, Internet access, no- or low-cost internal communications, low-cost external communications, secure transaction methods, access to clinical and financial data systems as well as more effectively manage and increase efficiency in our facilities. Our most recent additions have been expanded telehealth activities supported through a grant from HRSA's Office for the Advancement of Telehealth and the addition of the life-saving technology eICU from Visicu. Both of these additions would likely have not been possible without support from the Universal Service Fund.

The Rural Health Care (RHC) support mechanism has driven down the costs of our communications network by over 60% for our RHC supported hospitals and clinics and provides support to approximately 45 of our locations. We have participated in the program since its inception in 1998. We are very appreciative of this support and of the modifications to the program over the last five years. The program has provided approximately $2.0 million in support to our rural healthcare providers through June 30, 2005. We estimate that it will provide approximately $491,000 in support to our facilities for the current funding year of July 1, 2004 to June 30, 2005.

Please review our comments below as they relate to the November 19, 2003 "Report and Order, Order on Reconsideration, and Notice of Proposed Rulemaking", WC Docket No. 02-60.

Respectfully submitted,



Jason C. Wulf
Financial Analyst

CC: Sen. John Thune, (R-SD)
Sen. Tim Johnson, (D-SD)
Rep. Stephanie Herseth, (D-SD)
National Rural Health Association
American Hospital Association

Comments on Further Notice of Proposed Rule Making

Internet Access

Avera Health is very much in favor of increasing the percentage discount that the Commission provides through the Universal Service/Rural Health Care (RHC) mechanism. Avera currently spends $1,350 monthly for internet access for a portion of its wide area network (WAN). That $1,350 buys us a 7 megabit (MB) connection that is administered by Avera's urban hospital and is shared among approximately 50 individual locations. The 25% discount results in a $337.50 savings, however spread over 50 locations the result is only a savings of $6.75 per month per location, not all of which are RHCD eligible. Frankly, the amount of paperwork and time required per location is not worth the 25%. Avera would support a discount of up to 75%. The total impact to the program currently for Avera's internet access is $4,050 at the 25% discount. At 75% it would increase to $12,150 which is only a marginal increase of $8,100. The monthly savings per location would be $20.25 which would be worth the time to file.

Avera would like to also request that the Commission clarify the current rules or draft new rules such that larger systems, like Avera, can easily determine how to file for the Internet discount or possibly, simply file as a system instead of each individual location and reduce the funding by the percentage of the locations that are not eligible for the program. For example, Avera has roughly 50 locations that share one internet connection. This happens to be the most efficient method of connection for our network and is also the most easily controlled for appropriate use. The problem is that Avera's urban location has 2,500+ users while other rural locations have between 2 and 300 with a total of approximately 7,000 users total sharing this one Internet connection. The current rules do not clarify how we must allocate the cost. Also, the internet access charge is built into our network fees so each location is not specifically charged for internet access and given that, it is not clear if each location could then file for the discount since each location can not prove that it is paying for the access in the first place.

Support for Other Telecommunications Services for Mobile Health Care Providers

While any impact to the program would be extremely difficult to predict, Avera supports allowing Mobile Health Care Providers to utilize and receive support for services other than satellite. Currently, other wireless options are available in some, not all, areas and new technologies will further expand wireless alternatives to satellite and wired network access. One example is Sioux Valley Wireless (www.siouxvalleywireless.com). Sioux Valley Wireless' website lists its most expensive business rate for internet of $499.95 per month which provides speeds between 512k and 1024k download and up to 450k upload. While slightly slower than the satellite service, the cost is much less as well. This type of service coupled with VPN access could be utilize to securely transmit sensitive, private medical information. Some cellular phone companies, Verizon for example, are also offering wireless internet access through their networks. As speeds increase on these and

other alternative networks, they are, or will be, less expensive alternatives to satellite data services.

Support for Infrastructure Development

Avera's position regarding the support for infrastructure development is that the Commission first needs to clarify exactly who is eligible to receive funds for infrastructure build out and exactly what those funds can be used for. The current language can be interpreted more than one way. For example, if a rural clinic needs ISDN service for telemedicine, but the local phone company needs to install some equipment to be able to provide that service, is that an eligible use of the infrastructure support? Or, for example, if the clinic needs to install network hardware (routers, wiring, switches, etc) to be able to access a telemedicine wide area network (WAN), is that an eligible use of the funds? Or are both eligible uses?

Depending on the intention of the Commission, Avera supports one type of use, but not the other. The Rural Health Care section of the USAC is not the appropriate funding mechanism for the build out of new infrastructure that would be located at the telecommunications company. There are various other funding mechanisms such as the Rural Utilities Service that provides funds for that exact purpose. Avera does feel that it would be an appropriate use of funds to purchase and install networking equipment that is required to connect to a telecommunications or data service. However, this needs to be clearly defined as well, otherwise expenditures could become out of control as providers request funding for not only networking equipment, but also the telemedicine equipment or data and information systems. There are various other funding sources for these types of equipment as well such as the Office for the Advancement of Telehealth which is part of HRSA. In short, a clearly defined use of infrastructure funds is needed before clear, concise comments can be filed.